AB 937 (Koretz)

As Introduced – February 23, 2001

"HIV Treatment: Risk Adjusted Capitation"

FACT SHEET

PURPOSE

AB 937 is intended to increase access to high-quality, cost-effective health care for HIV patients by increasing their participation within health plans. The directed care provided in an HMO would benefit HIV infected individuals by carefully following the patient's condition and providing ready access to specialty care for this chronic condition – thus reducing overall costs.

AB 937 is designed to help ensure that health care providers serving patients with HIV are adequately compensated for the care they provide this high risk population. AB 937 will also help shield specialized providers from adverse selection.

SUMMARY

AB 937 requires all private health care service plans to develop and file with the Department of Managed Health Care a plan establishing risk-adjusted capitated rates for the reimbursement of providers for the treatment of enrollees infected with HIV.

The bill also requires the Department of Health Services to develop risk-adjusted capitated rates for Medi-Cal beneficiaries with HIV who are enrolled in managed care plans.

AB 937 further requires both departments to to develop an independent review of the rates, prior to their implementation, to insure consistency with efficiency, cost effectiveness, quality of care and access to care.

COMMENTS

As of 1997, over 250,000 Californians were living with HIV and more than 70,000 have died from HIV-related illnesses. Approximately 35 percent of all California AIDS cases to date are in Los Angeles County.

Changes in HIV Health Care. Over the last two decades, there has been enormous change in the way both publicly supported and private health care is being delivered and financed. Most state Medicaid programs are shifting rapidly from a traditional fee-for-service structure to risk-based capitated managed care systems. This same shift is happening in the private insurance market.

HIV and AIDS health care is continually faced with new challenges in the delivery of high quality health care. The medical complexities of the diseases caused by HIV

infection are increasingly reflected in the clinical and financial burden of delivering HIV care. Physicians must scramble to stay current with the latest developments in AIDS medicine so that they may competently render specialized HIV primary care and coordinate the additional involvement of sub-specialists and other health professionals. Additionally, HIV providers must capably navigate a changing fiscal model.

In addition, increasing numbers of women, children, heterosexuals and intravenous drug users are contracting HIV – presenting multiple service delivery problems for providers. Now more than ever, AIDS requires well-trained and experienced providers to render cost-effective high quality care.

It now costs almost as much to care for a person infected with HIV as it does to care for a person who has developed AIDS.

HIV and Managed Care. Until now the impact of managed-care expansion has been primarily on those who are healthy and require little in the way of health services. However, as managed care continues to grow, there are real concerns about a lack of proper care delivery and financing structures to insure adequate care for those with more complex, chronic illnesses like HIV and AIDS.

The very significant advances in treatment of HIV, and the capacity of medicine to delay and diminish symptoms of the disease, make HIV care management more significant and valuable. Managed care has the capacity to provide comprehensive and coordinated care and to be rational and systematic when employing new and/or alternative modes of care.

Capitation. Many public and private health systems are moving toward capitation payments as a way to pay for health services. Capitation, also referred to as "per member per month" or "PMPM," is a monthly payment for each beneficiary that is intended to cover all services required in that month. Structured appropriately, capitation can encourage prevention, early diagnosis, and appropriate treatment.

However, in some capitated plans, capitation rates may be inadequate to provide all necessary HIV/AIDS services, drugs and testing. Capitation can also provide an economic incentive to underserve patients by denying treatment or underutilizing preventive or active treatment services.

For capitation to work, it is necessary to have a mechanism that compensates providers fairly for attracting high risk, high cost patients***. Risk adjusted capitation***, where payers vary capitation rates according to predictable elements of risk, including demographic and geographic factors, and associated health related costs by disease, is one such mechanism.

Why risk-adjusted rates? Diagnosis-based risk-adjusted rates should be implemented for the protection of specialized providers and health plans, that deliver care to patients with high cost conditions from the inevitable problem of "adverse selection." Adverse selection is a competitive disadvantage for providers with reputations for excellence in treating patents with high cost conditions.

Risk-adjusted rates will also help ensure access to appropriate levels of care for person with HIV. One in four individuals starting treatment for HIV are not treated according to U.S. Health and Human Services HIV treatment guidelines. Women

and people of color have been found to suffer disproportionately from inferior medical care for HIV.

A Louis Harris Associates/Johns Hopkins/UCSF survey shows a high proportion of women and minorities receive care inconsistent with such guidelines. The survey results showed that physicians with the least experience treating HIV waited longer to begin treatment and prescribed fewer medications than recommended in the guidelines.

According to the survey, HIV treatment experienced physicians provide the most progressive care, and that physicians who receive new information and education on an ongoing basis are more likely to adopt and apply these treatment guidelines. Likewise, patients who are familiar with the health benefits related to new treatments will more likely seek and receive the most aggressive care. Physicians with the most experience in treating HIV more consistently prescribed according to the guidelines.

It is the experience of HIV health care providers that although plans will sign contracts with providers that have HIV expertise, such contracts go unutilized as managed care providers avoid attracting costly members.

The California Managed Care Improvement Task Force, noting that "good enough methods are now available and ought to be put into practice," has also recommended that "risk-adjustment should begin to be implemented as soon as possible. The Task Force recognized "that risk adjustment entails some extra cost and effort in the short run, and despite that, endorses risk adjustment as worth the additional investment."

However, rate-setting can not be arbitrary and capricious. The United States Court of Appeals for the Ninth Circuit found in Orthopaedic Hospital v. Kimberly Belshé that determination of Medi-Cal rates can not be "arbitrary and capricious," but rather that the Department of Health Services must "rely on responsible costs studies, its own and others', that provide reliable data as a basis for its rate setting."

STATUS

Assembly Health Committee – 4/24/01

SUPPORT

- AIDS Healthcare Foundation (sponsor)
- Lambda Letters Project
- Comprehensive AIDS Resource Education Program
- Northeast Valley Health Corporation
- Tarzana Treatment Centers
- Venice Family Clinic
- Whittier-Rio Hondo AIDS Project
- L.A. Gay and Lesbian Center

OPPOSITION

Employers Health Care Coalition of L.A.

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